

intra-fusal fibre with a deposit of hyaline material around. The ordinary muscular, nervous and vascular changes were also present.

JELLIFFE.

65. NOTE SUR LES RÉFLEXES FEMORAUX CROISÉS CHEZ LES ÉPILEPTIQUES (On Crossed Femoral Reflexes in Epileptics.) Ch. Féré (Comptes rend. Soc. de Biologie, 5, 1898, p. 7).

An examination by the author of some 143 non-paralytic epileptics, examined in a period when but few were deeply under the influence of bromides, revealed the presence of this phenomenon in twenty-four instances. The author presents the following table:—

	Patellar Reflex.	Crossed Femoral Reflex.
Feeble	35	—
Medium	64	8
Strong	44	16
Total	143	24

The variety of the crossed reflex varied; in 16 cases the r. adductor, in 3 the r. extensor and in 3 both muscles showed the phenomena. In general, the crossed femoral reflex was equal on both sides, save in one case, where the right side predominated.

Bromides seemed to have no influence upon either the patellar reflex or crossed femoral reflex.

VOGEL.

CLINICAL NEUROLOGY.

66. LA SCOMPARSA DEL RIFLESSO DEL TENDINE ACHILLEO NELL SCIATICA (Tendon Reflexes in Sciatica) J. Babinski (Gazz. d. Ospedali, 18, 1897, p. 29).

In a note the author shows that, whereas in healthy individuals the tendon-reflex is normal, in sciatica there is usually a diminution or a loss of such tendon-reflex. This phenomenon was found not only in severe cases of the disease, but also in much lighter forms, as ischialgia. In some cases there were marked differences in the reflexes on opposite sides of the body.

The author considers this a valuable diagnostic sign, especially to differentiate simulation from hysterical sciatica. It is not clear, however, that incipient tabes is ruled out in this report.

JELLIFFE.

67. LE RÉFLEXE ROTULIEN DANS LA SYPHILIS (The Knee-Jerk in Syphilis.) Valentine Zaroubine (Jour. de Conn. Méd., March 11, 1897).

The author found the knee-jerk exaggerated in all syphilitic patients during the secondary stage. Following this increase, the excitability often fell and then regained its normal state.

MACALESTER.

68. CASES OF PSEUDO-HYPERTROPHIC PARALYSIS AND OTHER FORMS OF PROGRESSIVE MUSCULAR DYSTROPHY. Bryon Bramwell (Atlas of Clinical Medicine, iii., 1897, p. 95).

In an elaborate report the author presents the clinical histories of fifteen cases of pseudo-hypertrophic paralysis and one case of myopathic muscular atrophy affecting the face, tongue, ocular muscles, muscles of the head, neck, shoulder/girdle and upper extremities.

In about five cases detailed microscopical examinations were made of the muscles, the peripheral nerves and the spinal cord.

While there is little new in the communication, the detailed clinical examinations, large number of post-mortems made and the numerous illustrations render this contribution an important one.

JELLIFFE.

69. **ATROPHIA MUSCOLARE PROGRESSIVA SPINALE** (Progressive Spinal Muscular Atrophy). Morasca (Resoconto degli Ospedali di Genova, 1896).

The author describes a case of progressive muscular atrophy of the Aran-Duchenne type, and comes to the general conclusion that if the patient does not come to autopsy, a clinical diagnosis of this disease is alone possible; but that from a pathological point of view the findings may be syringomyelia, or an amyotrophic lateral sclerosis, or an anterior poliomyelitis, a chronic myelitis or a progressive muscular atrophy (Erb). The clinical diagnosis without anatomical confirmation is of relative value only.

VOGEL.

70. **UN CAS D'ATROPHIE MUSCULAIRE PROGRESSIVE DU TYPE DUCHENNE-ARAN.** (A Case of Progressive Muscular Atrophy of the Duchenne-Aran Type). Villers (Journ. Med. de Bruxelles, Jan. 14, 1897).

The case reported here occurred in a man 52 years of age, who five years previously suddenly became paralyzed in the right arm, which recovered in about three months. After this there set in a weakness and gradual atrophy of the muscles of the hand, of the thumb and fingers, which gradually progressed to the arm. One year after his first sudden attack of paralysis he had a peculiar attack of twitching in the left hand, and was taken to a hospital. His condition then showed marked atrophy of the upper extremities, main en griffe, fibrillary twitchings in the opponens pollicis and interossei of the left hand. The muscles of the neck and face were less involved. Sensation and reflexes intact. No reactions of degeneration.

The patient died two years after entering the hospital, having suffered from a number of epileptiform attacks, after each one of which the atrophy became more profound, although his condition had bettered by electrical and massage measures.

Autopsy showed a universal atrophy of the muscles, more profound on the right side. The spinal cord showed a decrease in the size of the anterior horns, the cells being decreased in size. Sections at the level of the anterior end of the optic thalamus showed the position of an old hemorrhage.

Microscopical examination showed general arterio-sclerosis, also involving the brain; degeneration of the muscular substance throughout; in the spinal cord absence of any fibre degenerations, marked atrophy of the ganglion cells of the anterior horns at the level of the cervical and upper dorsal regions. There were no marked changes found in the peripheral nerves, though some showed degenerative lesions.

JELLIFFE.

71. **EXISTE-T-IL UNE ATROPHIE MUSCULAIRE PROGRESSIVE ARAN-DUCHENNE** (Is there a Progressive Muscular Atrophy of the Aran-Duchenne Type?) P. Marie (Revue Neurologique, 5, 1897, p. 686).

In a short note the author discusses the type of progressive muscular atrophy of Duchenne. He states that this was described at a time when our knowledge of the nervous system was quite incomplete, and that subsequent investigations have shown that Duchenne's symptom complex includes a number of diseases, which later writers have been able to differentiate and render classic descriptions of the same.